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To the Government Reform Committee's Subcommittee on Criminal Justice, Drug Policy, and Human Resources
Related to Hearing on April 1, 2004
"Marijuana and Medicine: The Need for a Science-Based Approach"

Thank you for this opportunity to address the Committee on the important issue of "marijuana as medicine."

I am a psychiatrist, a physician and a public servant who has worked to reduce substance abuse for over thirty years. I received an M.D. from the Harvard Medical School in Boston, Massachusetts, and completed my psychiatric training at Harvard and the National Institutes of Health in Bethesda, Maryland.

My first testimony before a Congressional Committee took place thirty five years ago, in 1969, as part of the creation of the District of Columbia's Narcotics Treatment Administration under Mayor Walter E. Washington. Four years later, in 1973, President Richard M. Nixon appointed me to lead the nation's anti-drug efforts as America's second "White House Drug Czar." In that post, I served under Presidents Nixon and Ford. During this time, I also became the first director of the National Institute on Drug Abuse (NIDA) serving under Presidents Nixon and Ford as well as President Carter.

Following my government work, I founded the Institute for Behavior and Health, Inc., (IBH). In addition to my duties as President of this non-profit research and public policy organization, I maintain an active practice of psychiatry specializing in addiction and the anxiety disorders, and have been Clinical Professor of Psychiatry at the Georgetown University School of Medicine since 1980.

I am vice president of Bensinger, DuPont and Associates (BDA), a national consulting firm dealing with workplace substance abuse and with prescription drug abuse. BDA was founded in 1982 under the leadership of Peter Bensinger, who headed the Drug Enforcement Administration (DEA) at the same time that I headed NIDA.

My efforts to promote public understanding of drug abuse have included more than two hundred and fifty professional articles and eighteen books and monographs on a variety of health-related subjects. My books include *Getting Tough on Gateway Drugs: A Guide for the Family* [1], *A Bridge to Recovery: An*

Introduction to Twelve-Step Programs (written with John P. McGovern, M.D.) [2] and *The Selfish Brain: Learning from Addiction, with a Forward by Betty Ford* [3].

I am here today, speaking as President of IBH, to warn you about the danger of accepting smoked marijuana as medicine. The concept of "medical marijuana" is ironic because smoked marijuana is the cause of many serious health problems, and it is the solution to none.

I will not review here the adverse health effects of smoked marijuana since they have been carefully and comprehensively catalogued in a variety of publications from the National Institute on Drug Abuse and other sources over many years.

In summary, marijuana is the nation's most widely used illegal drug. Reducing the use of marijuana has been a central feature of the nation's drug abuse prevention efforts for more than half a century, a goal that has been endorsed by virtually all of the health experts serving in official roles over that time and supported by the leaders in both major political parties and by the large majority of elected officials over that extended period of time.

During the past half century, what public policy debate there has been over marijuana use—and this debate has sometimes been heated and highly visible—has centered on the best strategies to achieve the goal of reducing marijuana use. There has been no debate about the central public health goal of reducing the use of marijuana in the country. There is no serious support for tolerating the current high levels of marijuana use in the United States let alone support for encouraging wider use of this dangerous illegal drug.

Americans Deserve Safe Medicines

Why, given the abundance of evidence of smoked marijuana's harmful effects, is the misconception of "medical marijuana" so hard to overcome?

Some of the answers lie in the perception of marijuana as a folk medicine, one of the few offerings that were available to pre-scientific health practitioners. While it did have applications in Asian medicine at one time [4,5], by the 19th century marijuana was virtually forgotten for health-related purposes.

The idea that smoked marijuana could have medicinal benefit has in recent years been given new life by marijuana advocates despite clear and compelling evidence to the contrary. There are important differences between modern scientific medicine and folk remedies (see Table 1).

It is reasonable for modern scientific medicine to take advantage of the experience with folk medicines to provide useful clues to prompt further systematic investigations. During the past 100 years folk medicines have often been a useful starting point for scientific study. In every case this process has

led to more specific, and almost always synthetic, substances which were administered as single chemicals by the oral route of administration.

If any chemical in marijuana smoke were shown to be safe and effective as a treatment for any specific illness, it could be approved through the same procedures as any other medicine. If that happened I would be happy to support that use of the chemical, whether or not it was found in marijuana smoke, based on clear evidence that it was safe and effective in the treatment of one or more specific illnesses.

In 1975, under my leadership, NIDA sponsored a meeting of distinguished medical researchers to report on the therapeutic potential of marijuana. The proceedings were published in a 1976 book, *The Therapeutic Potential of Marihuana* [6], edited by Sidney S. Cohen and Richard C. Stillman, two scientists who could not be described as anti-marijuana. Their wise perspective is reflected in this passage from their Foreword:

> "It should not be expected, nor is it anticipated that some cannabinoid will be available commercially in the near future. The nature of the approval process is such that years elapse between initial testing, however promising, and final approval for marketing. This is particularly true for a completely new chemical entity, and even more so for one with a checkered reputation. Cannabis, itself, will never be adopted for medical indications. It contains dozens of constituents, some of which have undesirable effects. Delta-9-tetrahydrocannabinol is a possible candidate, but it is more likely that a synthetic analog, tailored to intensify the desired action and to avoid the undesired ones, will be preferred." [6]

Cohen and Stillman were remarkably accurate in their prediction that medical science would be able to synthesize any chemicals in marijuana which showed medical promise. Synthetic THC, by the name of Marinol, is now available by prescription. On the market since 1985, it has not been widely used because patients and physicians generally eschew it in favor of alternative medicines with more reliability and efficacy and with fewer side effects.

These earlier findings about the therapeutic potentials of marijuana were comprehensively endorsed by the 1999 study of the Institute of Medicine, *Marijuana and Medicine – Assessing the Science Base* [7].

With respect to the central question of the health effects of smoked marijuana as a potential medicine here is what that IOM report said,

> "In summary, there are many reasons to worry that for people who might choose to use marijuana as medicine—and especially those who smoke it—the drug could actually

> add to their health problems. Proof that habitual marijuana smoking does or does not lead to respiratory cancer awaits the results of extensive, carefully designed epidemiological studies. In the meantime it appears that, for people with chronic medical disorders or those with compromised respiratory or immune systems, smoking marijuana is likely to do more harm than good. Likewise, for people at risk of cardiovascular disease, pregnant women, and couples trying to conceive, the potential risks of either THC or smoked marijuana appear to exceed the potential medical benefits." [8]

While I have no quarrel with the first 5 of the recommendations of the IOM report about medical marijuana I note with deep concern that the IOM committee did not address the question of whether the many recommended studies of the potential therapeutic benefits of the individual chemicals in marijuana smoke was the best use of the scare public funds available for medical research. I doubt that privately-funded commercial research will have much interest in these chemicals compared to the thousands of more attractive alternative chemicals that they might invest in, but that is a matter for the market to arbitrate. With respect to the allocation of public funds, however, there is an important question about the assessment of the best interest of the public health when it comes to the allocation of research resources. The question of the best allocation of research dollars is best answered, after thorough consideration of the most promising ways to help the sick and the suffering, by the National Institutes of Health (NIH) and not in a political forum.

The medical marijuana advocates complain that drug abuse prevention professionals, like me, are inhibiting research on medical marijuana. The exact opposite is the case: it is virtually only the political smoke they blow up that leads to any funding in this area since the scientific interest, outside this political pro-marijuana controversy, is close to zero.

There is, however, a substantial difference between my views and those of the IOM committee with respect to their sixth and final recommendation:

> "Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions:
>
> - Failure of all approved medications to provide relief has been documented,
> - The symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs,
> - Such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness, and

- Involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use." [8]

I do not believe that even this limited use of smoked marijuana until further research is conducted is in the public interest. There are more effective, safer and better-tolerated medicines now available for all of the illnesses for which the marijuana advocates propose using smoked marijuana.

However, I would not object to the temporary, limited approval proposed by the IOM committee since it would be used by few people, especially if known drug abusers were screened out as they generally are from the outpatient use of controlled substances to treat other illnesses. What the IOM's committee proposed in their sixth recommendation was a compromise within the committee. It is a political compromise that may diffuse the political controversy now raging over "medical marijuana."

It is interesting to me that the "medical marijuana" advocates are loudly and consistently opposed to using purified chemicals instead of smoked marijuana. They are also loudly and consistently opposed to any delivery system except smoking, despite the known toxicity of smoking. They pose as concerned about patient welfare. They want to be seen a compassionate. How can it be explained that the only form of this "medicine" they support is smoked marijuana even though everyone who has studied this issue has concluded, as the IOM committee did, that smoking is inherently an unreliable and toxic route of administration for any medicine?

I can think of only one explanation: they are not interested in medicine at all. They are using the "medical marijuana" issue as a Trojan Horse to legitimize the use of marijuana in this country, and throughout the world. Since the widely-shared public health goal is to reduce marijuana (and other drug) use it should not be surprising that many people, including myself, object to labeling smoked marijuana as a medicine.

Burning leaves is not a modern drug delivery system, period. "Medical marijuana" is an oxymoron.

Conclusion

For more than three decades Americans have been subjected to a well-funded and persistent, but ill-founded effort to convince them that smoking marijuana is harmless to health and that smoking marijuana should be socially accepted. According smoked marijuana the status that comes with medical treatment increases its legitimacy and "normalizes" smoking marijuana.

More people need to see “medical marijuana” for what it is: a cynical fraud and a cruel hoax. The conflict we are discussing at this hearing today, in my view, is not about medicine; it is about the political exploitation of the public’s compassion for suffering sick people. Legitimizing smoked marijuana as a “medicine” is a serious threat to the health and safety of all Americans.

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Table One – Comparison of Folk Remedies and Modern Medicines

Folk Remedies	Modern Medicines
Use plant products composed of many chemicals	Use highly purified, usually synthetic chemicals
Treat poorly defined illnesses	Treat specific illnesses
Are based on little understanding of the pathophysiology of the disorders being treated	Elucidate the nature of the illnesses
Are based on little understanding of the role of the "medicine" in the therapy	Use medicines that have a recognized effect on pathological processes
Are used in inconsistent and hard-to-quantitate amounts	Are administered in controlled doses
Sometimes use smoking as a delivery system resulting in varying levels of chemical in patient body and the toxicity of smoke	Are taken orally which leads to steady blood levels

References

[1] DuPont RL: *Getting tough on gateway drugs: A guide for the family*. Washington, D.C.: American Psychiatric Press, 1984.

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[5] Rubin V: Cross-cultural perspectives on therapeutic uses of Cannabis. In: Cohen S & Stillman RC (eds.) *The Therapeutic Potential of Marihuana*. New York: Plenum Medical Book Company, 1976. Pp. 1-17.

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